PARENT / LEGAL GUARDIAN PERMISSION FORM
MSD ATHLETIC DEPARTMENT 2012-2013

_____ _____
STUDENT NAME **DATE OF BIRTH**

I hereby give my consent for the above-named student to represent his/her school in athletic activities, and to accompany any school team of which he/she is member on any of its local or out-of-town trips. I authorize the school to obtain, through a physician of its choice, and emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree we/I will not hold the school or anyone acting in its behalf responsible for any injury occurring to the above-named student in the course of such athletic activities or such travel.

Check all that apply:

	YES	NO
SUMMER CAMPS		
Football Camp	□	□
Volleyball Camp	□	□
FALL SPORTS		
Cheerleading	□	□
Football	□	□
Girls Volleyball	□	□
WINTER SPORTS		
Boys Basketball	□	□
Cheerleading	□	□
Girls Basketball	□	□
Wrestling	□	□
SPRING SPORTS		
Baseball	□	□
Girls Softball	□	□
Track and Field	□	□
SPRING CLINICS		
Football	□	□
Girls Volleyball	□	□
Weight Lifting	□	□

Please check all sports that your child will or may participate during the year not just this fall. Please check weight lifting if your child participates in any sports.

_____
STREET ADDRESS

_____
CITY-STATE-ZIP CODE

_____ _____
HOME TELEPHONE VP or TTY or VOICE **WORK TELEPHONE VP or TTY or VOICE**

_____
EMAIL ADDRESS

_____ _____
NAME OF PARENT / LEGAL GUARDIAN **PARENT'S / LEGAL GUARDIAN SIGNATURE DATE**

THIS FORM MUST BE COMPLETED IN ALL DETAILS AND FILED IN THE OFFICE OF THE ATHLETIC DIRECTOR BEFORE THE STUDENT WILL BE ALLOWED TO PRACTICE OR COMPETE IN ATHLETICS

MARYLAND SCHOOL FOR THE DEAF

2012 - 2013

STUDENT-ATHLETE CODE OF CONDUCT

I, _____, as a member of any MSD athletic team, will follow and respect the following rules and standards of conduct (behavior). I understand that penalty for misconduct (not following these rules) can result in suspension or dismissal from the team as determined by the Student Handbook.

1. I will be ***loyal*** to my school and team. I agree to keep a ***positive attitude*** of encouragement toward my teammates all the time. I will give ***100% effort*** at all times during practices and games.

2. I understand if I quit or am dismissed from the team during the season, I will lose my privilege of joining any sport in the following season. The Athletic Director may approve an exception if the coach supports one, or if the circumstances merit it. There will be a two-week grace period for this to occur.

3. I will treat all people with ***respect*** all the time.

4. I understand I am a student ***first*** and am committed to getting the best education I can. I will do my best in the classroom.

5. I will inform my coach of any academic problems I may encounter. This includes low grades, term papers or upcoming tests, where I may need help or tutoring.

6. I will ***safeguard my health***. I will not use any illegal or unhealthy substances, including alcohol, tobacco and drugs.

7. I will be ***on time*** to practices, meetings and games. I will follow my coach's dress and grooming code for both home and away games. Regardless of gender, hair color will be a natural tint if colored or dyed. No unusual or non-traditional haircuts or hairstyles will be allowed (i.e., Mohawks, reverse Mohawks, spiked hair, etc.).

8. I understand I must personally get permission from my coach if I know I must be late to, or miss a team function. I will also inform my coach immediately if there is a transportation problem. I understand that being late to any team events for no reason will not be tolerated.

9. I will inform my coach immediately of any illness or injury that may affect my playing ability. I understand this may affect my playing time.

10. I will take good care of my practice and game uniforms. I understand I will have to pay to replace them if I am responsible for damaging them.

I have read the above rules and standards. I agree to follow them.

_____ _____

Athlete Signature **Date**

_____ _____

Parent Signature **Date**

CONSENT FORM FOR MEDICAL CARE
School Year 2012 – 2013

STUDENT HEALTH CENTER

301-360-2040 Voice & TTY
240-575-2957 Video Phone
301-360-1410 Fax
shcnurse@msd.edu

✧

SATELLITE HEALTH CENTER

301-360-2095 Voice & TTY
240-575-2986 Video Phone
301-360-1471 Fax

✧

Frederick Campus
Established 1868

✧

Name of Student:_____ Date: _____

1. As the parent/guardian of the student named above, I understand that **I am responsible** for immunization and physical examinations for my child as well as for the managing for any fees for my child's total health care. I understand that **I am responsible** for notifying Maryland School for the Deaf of any aspects of my child's medical history of which the school should be aware of in the event of an emergency (e.g., allergies, or contagious illnesses such as pink eye or ringworm, heart conditions, and chronic medical conditions). ***I understand that if my child has a fever or other illness, he/she will need to stay at home until he/she has been free of fever and/or illness without the use of medications.***

2. I give my consent for emergency medical care (CPR) to be given to my child by MSD healthcare providers if necessary. I give my consent for my child to be transported to a medical facility for emergency medical, psychological, or surgical care by MSD healthcare providers or MSD staff while he/she is enrolled at the school. **This authorization does not include the right to authorize any surgical procedures of a non-emergency nature.**

3. If give my permission for any medication be prescribed to my child during the school year which I bring to the Student Health Center in the **original container from the pharmacy**, to be administered to my child by a School Nurse, (or by staff who accompany the student on field trips). I understand that unlabeled medications will not be given. **I understand that I must provide a Maryland State School Medication Administration Authorization Form signed by a physician or nurse practitioner and a parent/guardian for each prescribed medication to given at the school. I understand that if this form is not completed, the medication will not be given**. I understand that the Student Health Center strongly recommends that my child receive the first dose of any new medication at home.

4. I understand that I must keep a weekend and holiday supply of any routine medications at home. **No medications will be sent back and forth on weekends or holidays**.

5. I give the permission for my child to be administered over the counter medication by the School Nurse for treatment of minor medical issues as ordered by the Medical Director (e.g., Tylenol for headaches, Robitussin for cough, and Chloraseptic for sore throat).

6. I give consent for the athletic trainer at Maryland School for the Deaf to provide care and treatment to my child as indicated while he/she is enrolled in school sponsored sports.

7. I give consent for Maryland School for the Deaf to give information to the physician or any healthcare provider contacted in accordance with this form regarding treatment received at school

8. I give consent for Maryland School for the Deaf to provide vision screening as required by the State of Maryland.

9. I give consent for the Student Health Center to exchange information with the student's private physician or any healthcare provider contacted regarding treatment received at the School

10. I have read, understood, and consented to conditions of Maryland School for the Deaf medical policy. I understand that this policy shall apply to my child even as amended from time to time.

_____ _____
Parent's Signature Date

Maryland Schools
Record of
Physical Examination

To Parents or Guardians:

In order for your child to enter a Maryland Public school for the first time, the following are required:

- ***A physical examination by a physician or certified nurse practitioner must be completed within nine months prior to entering the public school system or within six months after entering the system.*** A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement. (http://www.dsd.state.md.us/comar/13a/13a.05.05.07.htm)

- ***Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade.*** A Maryland Immunization Certification form for newly enrolling students may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend school. This form can be found at: http://www.edcp.org/pdf/DHMH896new.pdf

- ***Evidence of blood testing is required for all students who reside in a designated at risk area when first entering Pre-kindergarten, Kindergarten, and 1st grade.*** The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: http://www.fha.state.md.us/och/pdf/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf

Exemptions from a physical examination and immunizations are permitted if they are contrary to a students' or family's religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine. Exemptions from Blood-Lead testing is permitted if it is contrary to a families religious beliefs and practices. The Blood- lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered in school, you must have the physician complete a medication administration form for each medication. This form can be obtained at http://www.marylandpublicschools.org/NR/rdonlyers/8D9E900E-13A9-4700-9AA8-5529C55F4C749/3341/medicationform404.pdf. If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.

Maryland State Department of Health and Mental Hygiene Maryland State Department of Education
Records Retention - This form must be retained in the school record until the student is age 21.

PART I – HEALTH ASSESSMENT
To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

Address (Number, Street, City, State, Zip) Phone No.

Parent/Guardian Names

Where do you usually take your child for routine medical care? Phone No.

Name: Address:

When was the last time your child had a physical exam? Month Year

Where do you usually take your child for dental care? Phone No.

Name: Address:

ASSESSMENT OF STUDENT HEALTH
To the best of your knowledge has your child any problem with the following? Please check

	Yes	No	Comments
Allergies (Food, Insects, Drugs, Latex)			
Allergies (Seasonal)			
Asthma or Breathing Problems			
Behavior or Emotional Problems			
Birth Defects			
Bleeding Problems			
Cerebral Palsy			
Dental			
Diabetes			
Ear Problems or Deafness			
Eye or Vision Problems			
Head Injury			
Heart Problems			
Hospitalization (When, Where)			
Lead Poisoning/Exposure			
Learning problems/disabilities			
Limits on Physical Activity			
Meningitis			
Prematurity			
Problem with Bladder			
Problem with Bowels			
Problem with Coughing			
Seizures			
Serious Allergic Reactions			
Sickle Cell Disease			
Speech Problems			
Surgery			
Other			

Does your child take any medication?
No Yes Name(s) of Medications:_____

Is your child on any special treatments? (nebulizer, epi-pen, etc.)
No Yes Treatment _____

Does you child require any special procedures? (catheterization, etc.)
No Yes
Parent/Guardian Signature_____Date:_____

PART II – SCHOOL HEALTH ASSESSMENT

To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade

1. Does the child have a diagnosed medical condition?
   No Yes_____

   _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
   No Yes_____

   _____

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/Orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider **or** a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicated medication and diagnosis.
   No Yes _____
   (**A medication administration form must be completed for medication administered in school).**

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
   No Yes _____

7. **Screenings** Tuberculin Test	**Results**	**Date Taken**
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

PART II – SCHOOL HEALTH ASSESSMENT – continued
To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name)_____ has had a complete physical examination and has:
**** no evident problem that may affect learning or full school participation **** Problems noted above

_____

Additional Comments:

**** CLEARED FOR SPORTS OF ANY TYPE ****

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for:

☐ Not cleared for [Sport(s)]: Reason:

Recommendation:

Physician/Nurse Practitioner (type or print)	Phone No.	Physician/Nurse Practitioner	Date

MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) _____ including the summer session.

School: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: ☐ None expected ☐ Specify: _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____
Signature Date

School RN approval for self carry/self administration of emergency medication: _____
Signature Date

Order reviewed by the school RN: _____
Signature Date

2004

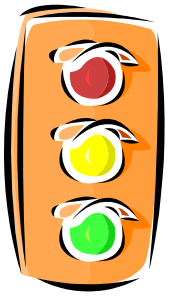
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Maryland Chapter

ASTHMA ACTION PLAN

Check Asthma Severity: ☐Mild Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent

Patient's Name	DOB	Effective Date ___/___/___ to ___/___/___
Doctor's Name	Parent/ Guardian's Name	
Doctor's Office Phone Number	Parent/ Guardian's Phone Number	
Emergency Contact after Parent	Contact Phone	



Personal Best Peak Flow: _____

Personal Peak Flow Ranges

RED means Danger Zone! Get help from a doctor. -- _____

YELLOW means Caution Zone! Add prescribed yellow medicine. -- _____

GREEN means Go Zone! Use preventive medicine. -- _____

GO (Green) → Use these medications every day.

You have *all* of these:
- Breathing is good.
- No cough or wheeze.
- Sleep through the night.
- Can work and play.

And/ or personal peak flow above 80 % _____

Medicine/ Dosage	How much to take	When to take it
Comments		

For exercise, take:

CAUTION (Yellow) → Continue with green zone medicine and ADD:

You have *any* of these:
- First sign of a cold.
- Exposure to a known trigger.
- Cough.
- Mild wheeze.
- Tight chest.
- Cough at night.

And/ or personal peak flow from 80% _____ To 50% _____

Medicine/ Dosage	How much to take	When to take it
Comments		

If Quick Reliever/ Yellow Zone medicines are used more than 2 to 3 times per week, CALL your Doctor.

DANGER (Red) → Take these medicines and call your doctor.

Your asthma is getting worse fast:
- Medicine is not helping within 15-20 minutes.
- Breathing is hard and fast.
- Nose opens wide.
- Ribs show.
- Lips are blue.
- Fingernails are blue.
- Trouble walking or talking.

And/ or personal peak flow below 50% _____

Medicine/ Dosage	How much to take	When to take it
Comments		

GET HELP FROM A DOCTOR NOW!

If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Trigger List:
- ❑ Chalk dust
- ❑ Cigarette smoke
- ❑ Colds/Flu
- ❑ Dust or dust mites
- ❑ Stuffed animals
- ❑ Carpet
- ❑ Exercise
- ❑ Mold
- ❑ Ozone alert days
- ❑ Pests
- ❑ Pets
- ❑ Plants, flowers, cut grass, pollen
- ❑ Strong odors, perfume, cleaning products
- ❑ Sudden temperature change
- ❑ Wood smoke
- ❑ Foods: _____ _____
- ❑ Other: _____

Adapted from: NYC DOHMH and Pediatric/ Adult Asthma Coalition of New Jersey.

www.fha.state.md.us/mch www.MarylandAsthmaControl.org www.mdaap.org

White Copy- Patient **Pink Copy- School** **Yellow Copy- Doctor**

DHMH Form Number: 4643

For additional forms, please call: 410-799-1940

How to Use this Form

The Asthma Action Plan is to be completed by a primary care provider for each individual (child or adult) that has been diagnosed with asthma. The Asthma Action Plan should be regularly modified to meet the changing needs of the patient and medicine regimes. The provider should be prepared to work with families to gain an understanding of how and when the Asthma Action Plan should be used. *Please complete all sections of the Asthma Action Plan. Please write legibly, and refrain from using abbreviations.*

The Asthma Action Plan is an education and communication tool to be used between the health care provider and the patient, with their family and caregivers, to properly manage asthma and respond to asthma episodes. The patient, and their family or caregivers, should fully understand the Asthma Action Plan, especially related to using the peak flow meter, recognizing warning signs, and administering medicines. Patients, families, and caregivers should be given additional educational materials related to asthma, peak flow monitoring, and environmental control.

Persons with asthma, parents, grandparents, extended family, neighbors, school staff, and childcare providers are among the persons that should use the Asthma Action Plan.

A spacer should be prescribed for all patients using a metered-dose inhaler (MDI).

Children over the age of six years may be given peak flow meters to monitor their asthma and determine the child's zone.
Parents of children under the age of six years should use symptoms to determine the child's zone.

Zone Instructions

The Personal Best peak flow should be determined when the child is symptom free. A diary can be used to determine personal best and is usually part of a peak flow meter package. A peak flow reading should be taken at all asthma visits and personal best should be redetermined regularly. Because peak flow meters vary in recording peak flow, please instruct your patients to bring their personal peak flow meter to every visit.

Green: Green Zone is 100 percent to 80 percent of personal peak flow best, or when no symptoms are present.
List all daily maintenance medicines. Fill in actual numbers, not percentages, for peak flow readings.

Yellow: Yellow zone is 80 percent to 50 percent of personal peak flow best, or when the listed symptoms are present.
Add medicines to be taken in the yellow zone and instruct the patient to continue with green zone (maintenance) medicines. Include **how long** to continue taking yellow (quick reliever) medicines and when to contact the provider.

Red: Red zone is 50 percent or below of personal peak flow best, or when the listed symptoms are present.
List any medicines to be taken while waiting to speak to a provider or preparing to go to the emergency room.

Peak Flow Chart

Green 100%	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320
Yellow 80%	80	90	95	105	110	120	130	135	145	150	160	170	175	185	190	200	210	215	225	230	240	250	255
Red 50%	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160

Green 100%	330	340	350	360	370	380	390	400	420	440	460	480	500	520	540	560	580	600	620	640	660	680	700
Yellow 80%	265	270	280	290	295	305	310	325	335	350	370	385	400	415	430	450	465	480	495	510	535	545	560
Red 50%	165	170	175	180	185	190	195	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350

MARYLAND SCHOOL FOR THE DEAF

Emergency Medical Information Form

(Must be completed signed by parent/guardian)

Student's Name: _____

Address: _____ Date of Birth: _____

_____ Social Security # ___ - ___ - ____
City State Zip Code

Parent/Guardian Name(s): Mother: _____ (H) ( ) - V - VP - TTY
(W) ( ) - V - VP - TTY
Pager # _____
Email _____

Father: _____ (H) ( ) - V - VP - TTY
(W) ( ) - V - VP - TTY
Pager # _____
Email _____

Additional Contact Person: Name: _____ (H) ( ) - V - VP - TTY
Relationship _____ (W) ( ) - V - VP - TTY
Pager # _____
Email _____

INSURANCE INFORMATION	Health Insurance Provider	Prescription Drug Plan	Other Insurance
Name of Company Address and Phone Number			
Policy Number			
Name of Policy Holder			

*******Attach Photo Copy of All Insurance Cards (front and back)!*******

SCHOOL INSURANCE: Yes _____ No _____

Physician's Name: _____ Phone Number: ( ) -

Allergies: _____ Health Concerns: _____
_____ Restrictions: _____

Date of Last Tetanus Shot: _____ Date of Last Physical Exam: _____

(Note: Student must have a completed <u>current</u> physical exam form to participate in any sport)

Any special requests: _____
_____

<u>Consent for Medical Care:</u>
In case of injury or sudden illness, I hereby authorize medical care to be provided by MSD Healthcare personnel. Further, I grant permission for any hospital or treatment facility to render immediate aid or emergency surgical care as might be required at the time for his/her health and safety. I understand that in order for medications to be administered, they must in the original pharmacy bottle with label attached and dated within one year. I also understand that over-the-counter medications must be accompanied with a written order form a physician. I give my permission for MSD personnel to administer such medications. Attempts to notify parents/guardians regarding a medical emergency will always begin immediately.

_____ _____
Parent/Guardian's Signature Date

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME_____
LAST FIRST MI

SEX: MALE Γ FEMALE Γ BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____
ADDRESS _____ CITY _____ ZIP_____

RECORD OF IMMUNIZATION : See Notes

VACCINE TYPE						VACCINE TYPE				
DOSE #	DTP-DTaP MO/DAY/YR	DT-Td MO/DAY/YR	Polio MO/DAY/YR	Hib MO/DAY/YR	Hep B MO/DAY/YR	DOSE #	M-M-R MO/DAY/YR	MEASLES MO/DAY/YR	RUBELLA MO/DAY/YR	MUMPS MO/DAY/YR
1						1				
2						2				
3						DOSE #	Varicella MO/DAY/YR	OTHER VAX MO/DAY/YR	OTHER VAX MO/DAY/YR	OTHER VAX MO/DAY/YR
4						1				
5						2				

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. _____
Signature Title Date
2. _____
Signature or Initial Title Date
3. _____
Signature or Initial Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

LOST OR DESTROYED RECORDS: (Must Be Reviewed and Approved by Local Health Department. See Notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed _____ Date _____
Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:
The physical condition of the above pupil is such that immunization at this time would constitute a serious threat to his/her health.
This is a permanent condition Γ temporary condition Γ until _____/_____/_____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed _____ Date _____
Physician or Health Official

RELIGIOUS OBJECTION:
I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunization being given to my child.
Signed_____ Date _____

CERTIFICATION INFORMATION

The following excerpt from the DHMH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A school principal or other person in charge of a school, public or private, may not knowingly admit a student to, or retain a student in a: 1) preschool program unless the student has furnished evidence of age-appropriate immunity against Haemophilus influenzae type b 2) preschool program or kindergarten through the second grade of school unless the student has furnished proof of age-appropriate immunity against pertussis; and 3) preschool program through the twelfth grade unless the student has furnished evidence of age-appropriate immunity against tetanus, diphtheria, poliomyelitis, measles (rubeola), mumps, rubella, hepatitis B and varicella."

Please refer to the **"Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools"** to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and DHMH COMAR 10.06.04.03 are available at www.edcp.org (click "Immunization").
The requirement for hepatitis B and varicella vaccine is a "progressive" regulation in which each new school year another successive grade becomes covered by the regulation (e.g., kindergarten in 2001, 1st grade in 2002, etc.).

Age-appropriate immunization requirements for licensed child care centers and family day care homes are based on the **"Maryland DHMH Recommended Childhood Immunization Schedule"**. Please refer to Department of Human Resources COMAR 07.04.02.44 and COMAR 07.04.01.29 for day care regulations. DHR COMAR regulations and the "Maryland DHMH Recommended Childhood Immunization Schedule" are available at www.edcp.org (click "Immunization").

HOW TO USE THIS FORM

The medical provider that gave the vaccinations may record the dates directly on this form (check marks are not acceptable) and certify them by signing or stamping the signature section. A different medical provider, a local health department official, a school official, or a day care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or day care service.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **measles, mumps, or rubella**.

   Reconstructed dates for all vaccines must be reviewed and approved by the local health department.

   Blood test results are NOT acceptable evidence of DTP/DTaP/DT/Td immunity.

   Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

2. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

CHILD'S NAME_____/_____/_____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____/_____/_____/_____
ADDRESS CITY STATE ZIP

SEX: ☐ MALE ☐ FEMALE BIRTHDATE_____/_____/_____

COUNTY _____ SCHOOL_____ GRADE_____

PARENT OR GUARDIAN _____/_____/_____/_____
LAST FIRST MIDDLE PHONE

_____/_____/_____/_____
ADDRESS CITY STATE ZIP

CERTIFICATION INFORMATION

The following applies to blood lead testing requirements and the duties of health care providers, parents/guardians, and the public schools:

1. The health care provider for a child who resides in an at-risk area, or has ever resided in an at-risk area as designated by the Maryland Targeting Plan for Childhood Lead Poisoning, shall administer a blood test for lead poisoning during the 12-month visit and again during the 24-month visit. At-risk areas by Zip Code are listed on the back of this form.
2. Beginning not later than September 2003**,** the parent or guardian of a child who currently resides, or has ever resided, in an at-risk area, shall provide to the designated administrator of the child's school or program, evidence that the child has had blood lead testing, on entry into a Maryland public pre-kindergarten program or Maryland public school system at the level of pre-kindergarten, kindergarten or first grade.
3. Evidence of blood testing for lead poisoning sent to or received by a program or school shall be documented on a form approved by the Department that includes the following: name of the child, address of the child, date of the blood test(s) for lead poisoning, and the signature of the child's health care provider or designee, or school health professional or designee that transcribed the information onto the approved form.
4. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

RECORD OF BLOOD LEAD TESTING

Test #1. _____ **Test # 2.** _____ Comments: _____
Date Date

Signature _____/_____
Health Care Provider or Designee OR School Health Professional or Designee Date

RECORD OF BLOOD LEAD TESTING EXEMPTION

I, _____ certify that my child does not **AND** has never resided in an at-risk area.
Parent or Guardian (Print)

Signature_____ / _____
Parent or Guardian Date

COMPLETE THE SECTION BELOW IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS. ANY LEAD TESTS THAT HAVE BEEN ADMINISTERED SHOULD BE ENTERED ABOVE. A LEAD RISK ASSESSMENT QUESTIONNAIRE MUST BE ADMINISTERED BY A HEALTH CARE PROVIDER IF THE CHILD IS EXEMPT FROM LEAD TESTING ON RELIGIOUS GROUNDS.

RELIGIOUS OBJECTION:

1. I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child. Signed _____ / _____
Parent or Guardian Date
2. Lead Risk Assessment Questionnaire Administered: YES ☐ NO ☐ Signed_____/_____
Health Care Provider Date

HOW TO USE THIS FORM

The documented tests should be the tests at 12 months and 24 months of age. Two test dates are required if the 1st test was done prior to 24 months of age. If the 1st test is done after 24 months of age, one test date is required. The child's **primary health care provider** may record the test dates directly on this form (check marks are not acceptable) and certify them by signing or stamping the signature section. A **school health professional or designee** may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

Maryland Childhood Lead Poisoning Targeting Plan
At Risk Areas by Zip Code

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237

Baltimore Co. (Cont.)
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727

Frederick . (Cont)
21757
21758
21762
21769
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787

Montgomery (Cont)
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate http://www.fha.state.md.us/och/html/lead.html